Incontinence Supplies (Age 21 and over)

Definition: Diapers, underpads, wipes, liners, and disposable gloves provided to participants who are at least **twenty-one (21) years old** and who are incontinent of bowel and/or bladder according to the established medical criteria.

Providers: Incontinence supplies must be provided by licensed **vendors enrolled with SCDHHS as Incontinence Supply providers.**

Criteria: The following criteria must be met for individuals to receive incontinence supplies:

1. The waiver participant must be age 21 or older.
2. The waiver participant's inability to control bowel or bladder function must be confirmed by a Physician on the **Physician Certification of Incontinence (DHHS Form 168IS**).
3. The Service Coordinator must conduct an assessment to determine the frequency and amount of supplies authorized.

Covered Supplies: Medically necessary incontinence supplies are available through the Medicaid State Plan. They must be accessed prior to the CS Waiver.

Medicaid State Plan offers the following based on medical necessity:
One (1) case of diapers or briefs [1 case = 96 diapers or 80 briefs]
One (1) case of incontinence pads/liners [1 case = 130 pads]
One (1) case of underpads
One (1) box of wipes
One (1) box of gloves

In addition to incontinence supplies offered by Medicaid State Plan, the CS Waiver may offer the following additional incontinence supplies based on documented need in the individual's record. Please note: it is possible that incontinence supplies offered by the Medicaid State Plan and the CS Waiver may not meet the requests presented by all waiver participants.

- One (1) box of disposable gloves monthly
- Up to two (2) cases of diapers/briefs monthly [1 case = 96 diapers or 80 briefs]
- Up to two (2) cases of underpads monthly
- Up to eight (8) boxes of wipes monthly
- Up to two (2) cases of incontinence pads (liners) monthly [1 case = 130 pads]

Arranging for the Service: Once the individual's need has been identified and documented in the plan and the participant's record, you must determine if the individual is eligible for incontinence supplies by having a physician complete the **Physician Certification of Incontinence (DHHS Form 168IS).** This form must be completed annually. Upon completion of the physician certification, you must conduct a telephone assessment to determine the frequency of incontinence and the amount of supplies to be authorized. The frequency definitions are as follows:

Occasionally Incontinent =

- Bladder—Not daily. Approximately 2 or less times a week
- Bowel—Approximately once a week

Frequently Incontinent =

- Bladder—Approximately between 3 to 6 times a week, but has some control OR if the client is being toileted (w/extensive assistance) on a regular schedule.

- Bowel—Approximately between 2 to 3 times a week.

Totally Incontinent =

- No control of bladder or bowel

NOTE: If the individual has an ostomy or catheter for urinary control <u>and</u> an ostomy for bowel control, <u>only</u> underpads may be authorized.

NOTE: If the individual has an appliance for bowel <u>or</u> bladder control, diapers may be authorized based on the frequency of incontinence.

Once a frequency and amount has been determined, the individual must make a choice of provider and you must complete the A**uthorization for Incontinence Supplies (Form IS-1)** and send it to the provider. A copy of the authorization must remain in the individual's file.

<u>Note:</u> A**uthorizations for wipes are based on the presence of an incontinence need only; therefore, <u>an individual must also be receiving diapers and/or underpads in order to receive wipes. Wipes cannot be authorized for cosmetic or other general hygiene purposes. They can only be authorized for the participant's incontinence care.</u>**

<u>Monitoring the Services:</u> You must monitor the effectiveness, frequency, duration, benefits, and usefulness of the service along with the individual's/family's satisfaction with the service. Information gathered during monitoring may lead to a change in the service, such as an increase/decrease in units authorized, change of provider, change to a more appropriate service, etc. Incontinence Supplies must be monitored at least monthly for the first two months and then at least quarterly thereafter. You must start the monitoring process over with each new provider

<u>Questions to include in your monitoring:</u>

- → Has the individual's health status changed since your last monitorship? If so, do all authorized supplies continue to be needed at the current rate?
- → Are the amounts appropriate or do they need to be changed?
- → Has the participant improved in his/her ability to toilet? If so, can the amount of supplies be decreased?
- → Are there any new needs?
- → Does the individual receive his/her monthly supplies in a timely manner?
- → When was the last time the supplies were received?
- → Is he/she satisfied with the provider of the service?

<u>Reduction, Suspension, or Termination of Services:</u> If services are to be reduced, suspended, or terminated, a <u>written</u> notice must be forwarded to the individual or his/her legal guardian including the details regarding the change(s) in service, allowance for appeal/reconsideration, and a ten (10) calendar day waiting period before proceeding with the reduction, suspension, or termination of the waiver service(s). See **Chapter 8** for specific details and procedures regarding written notification and the appeal process.

SCDDSN RECONSIDERATION PROCESS AND SCDHHS MEDICAID APPEALS PROCESS

The SC Department of Disabilities and Special Needs (SCDDSN) is responsible for the day-to-day operations of the Intellectual Disabilities/Related Disability (ID/RD) Waiver, the Community Supports (CS) Waiver, the Head and Spinal Cord Injury (HASCI) Waiver and the Pervasive Development Disorder (PDD) Waiver. A request for reconsideration of an adverse decision **must be** sent in writing to:

SC Department of Disabilities and Special Needs
Attn: State Director
P. O. Box 4706
Columbia, SC 29240

The SCDDSN reconsideration process must be completed in its entirety before appealing to the South Carolina Department of Health and Human Services (SCDHHS).

A formal request for a reconsideration must be made in writing within thirty (30) calendar days of receipt of written notification of the adverse decision. The request must state the basis of the complaint, previous efforts to resolve the complaint and the relief sought. The reconsideration request must be dated and signed by the participant, representative, or person assisting the consumer in filing the request. If necessary, staff will assist the consumer in filing a written reconsideration.

Note: In order for waiver benefits/services to continue during the reconsideration/appeal process, the individual/representative's request for reconsideration must be submitted within ten (10) calendar days of the written notification of the adverse decision. If the adverse action is upheld, the individual/representative may be required to repay waiver benefits received during the reconsideration/appeal process.

The State Director or his designee shall issue a written decision within ten (10) working days of receipt of the written reconsideration request and shall communicate this decision to the individual/representative. If the State Director upholds the original adverse action/decision, the reason(s) shall be specifically identified in the written decision.

If the individual/representative fully completes the above reconsideration process and is dissatisfied with the results, the individual/representative has the right to request an appeal with the SCDHHS. The purpose of an administrative appeal is to prove error in fact or law. The individual/representative must submit a written request to the following address no later than thirty (30) calendar days from the receipt of the SCDDSN written reconsideration decision.

Division of Appeals and Hearings
SC Department of Health and Human Services
PO Box 8206
Columbia, SC 29202-8206

The individual/representative must attach copy of the written reconsideration notifications received from the SCDDSN regarding the specific matter on appeal. In the appeal request the individual/representative must clearly state with specificity, which issue(s) the individual/representative wishes to appeal.

Unless the request is made to the above address within thirty (30) calendar days of the receipt of the SCDDSN written reconsideration decision, the SCDDSN decision will be final and binding. An appeal request is considered filed at the above address if postmarked by the thirtieth (30^{th}) calendar day following receipt of the SCDDSN written reconsideration decision. The individual/representative shall be advised by the SCDHHS Division of Appeals and Hearings as to the status of the appeal request.

S. C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS

COMMUNITY SUPPORTS WAIVER

AUTHORIZATION FOR INCONTINENCE SUPPLIES FOR INDIVIDUALS AGE 21 AND OVER

BILL TO S.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES (include Prior Authorization # below)

TO: _____
Provider Name

Participant's Name: _____ **Date of Birth:** _____ **(Must be over 21 years old)**

Address: _____
_____

Phone Number: _____ **Medicaid #:** _____

Prior Authorization # CS ___/___/___/___/___

NOTE: The provider is responsible for pursuing all other resources prior to accessing Medicaid. State Plan Medicaid resources must be exhausted before accessing the CS Waiver. Our information indicates this person has:

☐ Medicaid only ☐ 3rd Party liability (private insurance) ☐ Medicare

You are hereby authorized to provide the following service(s) to the person named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for these services.

*****ATTENTION PROVIDERS: All WAIVER procedure codes for incontinence supplies must be billed using the modifier "SC". STATE PLAN Procedure Codes for incontinences supplies below DO NOT require a modifier. The quantity must be indicated for each procedure code in order for claims to pay correctly. State Plan and Waiver procedure codes must be billed on separate lines of the claim form.***

Quantity of Items:

☐ **Diapers*:** _____ diapers billed through State Plan (Maximum 96 diapers), _____ diapers billed through Waiver (Maximum 192 diapers)
Size: ☐ Adult SM (T4521) ☐ Adult MD (T4522) ☐ Adult LG (T4523) ☐ Adult XL (T4524) ☐ Bariatric (T4543)
Diaper Frequency: ☐ Monthly ☐ Bi-Monthly ☐ Quarterly **Start Date:** _____

☐ **Briefs*:** _____ briefs billed through State Plan (Maximum 80 briefs), _____ briefs billed through Waiver (Maximum 160 briefs)
Size: ☐ Adult SM (T4525) ☐ Adult MD (T4526) ☐ Adult LG (T4527) ☐ Adult XL (T4528)
Brief Frequency: ☐ Monthly ☐ Bi-Monthly ☐ Quarterly **Start Date:** _____

☐ **Incontinence Pads (liners) (T4535):** _____ liners billed through State Plan (Maximum 130 pads), _____ liners billed through Waiver (Maximum 260 pads)
Pad Frequency: ☐ Monthly ☐ Bi-Monthly ☐ Quarterly **Start Date:** _____

☐ **Under Pads (A4554):** _____ cases billed through State Plan (Maximum 1 case), _____ cases billed through Waiver (Maximum 2 cases)
Under Pad Frequency: ☐ Monthly ☐ Bi-Monthly ☐ Quarterly **Start Date:** _____

☐ **Wipes (T5999):** _____ boxes billed through State Plan (Maximum 1 box), _____ boxes billed through Waiver (Maximum 8 boxes)
Wipe Frequency: ☐ Monthly ☐ Bi-Monthly ☐ Quarterly **Start Date:** _____

☐ **Gloves (A4927):** _____ box billed through State Plan (Maximum 1 Box), _____ box billed through Waiver (Maximum 1 box)
Glove Frequency: ☐ Monthly ☐ Bi-Monthly ☐ Quarterly **Start Date:** _____

**Briefs and Diapers combined cannot equal more than a total of 3 cases per month (96 diapers per case, 80 briefs per case)*

Service Coordination Provider: _____ Service Coordinator Name: _____

Address: _____
_____

Phone # _____

_____ _____
Signature of Person Authorizing Services Date